STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155711	A. BUILDING 01 B. WING	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR HEALTHCARE	2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/22/11 Facility Number: 000567 Provider Number: 155711 AIM Number: 100289560 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Highland Manor Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and all areas not separated from the corridor. Battery operated smoke	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	detectors are provided in each of the resident rooms. The facility has a capacity of 52 and had a census of 41 at the time of this visit. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/28/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 8 of 8 openings through 3 of 4 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke	K0025	All residents, families, staff and visitors have the potential to be affected. All smoke barriers have been inspected and repairs to small holes have been filed with fire/smoke retardant caulk. Larger holes have been repaired with appropriate fire/smoke retardant materials. Safety committee will monitor for any future construction and repairs to areas of the smoke barriers. Maintenance supervisor will inspect all barriers twice a year	09/26/2011

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	resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any resident, staff or visitor in the vicinity of the smoke barrier walls near Room 20, Room 9 and near the Maintenance Closet. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, the following was noted: a) The smoke barrier wall above the ceiling near Room 20 had two openings each measuring two inches in diameter which were not firestopped. b) The smoke barrier wall above the ceiling near Room 9 had four openings each measuring one inch in diameter which were not firestopped. c) The attic smoke barrier wall above the corridor by the Maintenance Closet had a four inch hole which was not firestopped. d) The attic smoke barrier wall above the corridor by the Maintenance Closet had an access panel cut in the wall measuring five feet high by three feet wide. The access panel was open to the adjoining smoke compartment. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the smoke barrier walls		for compliance. Maintenance supervisor is responsible. Completed 9-26-2011 and on-going	

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	above the ceiling by Room 20 and Room 9 had openings which were not firestopped, the smoke barrier wall in the attic by the Maintenance Closet had a four inch opening which was not firestopped and had an open access panel cut into the wall which was not replaced. 3.1-19(b)			
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 4 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect any resident, as well as staff and visitors in vicinity of the door sets by Room 9 and by Room 30 if smoke was allowed to move from one smoke compartment to another. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, the north door in each set of	K0027	All residents, families, staff and visitors have the potential to be affected. Smoke barrier doors at rooms 9 and 30 adjusted to allow free closure upon fire alarm system activation. Safety committee will monitor quarterly with fire drills. Maintenance supervisor will test doors in monthly maintenance rounds. Maintenance supervisor is responsible. Completed 9-26-2011 and on-going	09/26/2011

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	smoke barrier door sets in the corridor by Room 9 and by Room 30 failed to close and left a three foot gap between each door in the door set when the fire alarm alarm system was activated at 12:58 p.m. Each door in the door sets by Room 9 and Room 30 are held open by magnetic devices which released when the fire alarm was activated but the bottom of the north door in each door set was hitting the floor and failed to swing freely. Based on interview at the time of observation, the Maintenance Supervisor stated the bottom of the north door in each door set was hitting the floor and acknowledged each of the two corridor smoke barrier door sets failed to close completely to form a smoke resistant barrier. 3.1-19(b)			
K0038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 6 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without	K0038	All residents, families, staff and visitors have the potential to be affected. All exit doors with an exit access code for the mag-lock have the access code on the top of the access key panel. Safety committee will monitor quarterly for compliance. Should the code need to be changed, Safety committee will approve and designate the code. Maintenance supervisor is responsible for changing code and replacing the key panel codes. Completed	09/26/2011

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	delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects all residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, all 6 exit doors were magnetically locked and could be opened by entering an exit access code, but the code was not posted at each exit. Based on interview with the Executive Director during the tour of the facility at 12:45 p.m. on 09/22/11, the Executive Director stated all residents are an elopement risk but the facility does not house residents with a clinical diagnosis requiring specialized security measures and acknowledged the exit access code was not posted at each of six exits. 3.1-19(b)		9-26-2011 and on-going	
K0045 SS=E	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8			

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	Based on observation and interview, the facility failed to ensure the lighting for 1 of 6 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any resident, staff or visitor if needing to exit the facility from the northeast exit by Capitol Avenue. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, the exit means of egress from the northeast exit by Capitol Avenue is equipped with one light fixture with only one bulb. Based on interview at the time of observation, the Maintenance Supervisor acknowledged only one light fixture with one bulb was provided at the northeast exit by Capitol Avenue.	K0045	All residents, families, staff and visitors have the potential to be affected. A second bulb was installed on the northeast exit by Capitol Avenue. Safety committee will monitor for compliance. Maintenance supervisor is responsible. Completed 9-26-2011 and on-going	09/26/2011
K0048 SS=F	3.1-19(b) There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include: A) the use of kitchen fire extinguishers, and B) staff response to resident room battery operated smoke detector activation	K0048	All residents, families, staff and visitors have the potential to be affected. Fire Disaster Plan updated to include the use of the overhead hood extinguishing system to suppress a fire first and when to use either the ABC or K class fire extinguisher in the	09/26/2011

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	in the written fire safety plan for the protection of 41 of 41 residents in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents in the facility. Findings include: Based on a review of the facility's written fire disaster plan labeled "Fire Disaster Plan" for Highland Manor Healthcare with the Maintenance Supervisor from 9:15 a.m. to 11:20 a.m. on 09/22/11, the fire disaster plan did not address the use of the ABC type fire extinguisher and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system and did not address staff response to activation of resident room battery operated smoke detectors. Based on an		kitchen. All kitchen staff in-serviced on extinguisher classes and uses. Fire Disaster Plan updated to include resident battery operated smoke detector activation response by staff. All staff in-serviced. New employee files updated with new policy. Safety committee will monitor for compliance. Maintenance supervisor is responsible. Completed 9-26-2011 and on-going	

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	interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher and acknowledged the written fire safety plan did not include staff response should resident room battery operated smoke detectors be activated. 3.1-19(b)			
K0052 SS=E	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests	K0052	All residents, families, staff and visitors have the potential to be affected. Smoke detectors listed as “No-detect pass” had been repaired and retested by service contractor. Documentation was lacking for proof. Documentation has been requested from contractor. Safety committee will quarterly monitor documentation of Sensitivity Testing and repairs as indicated. Committee will provide Administrator with copies of all documentation. Maintenance supervisor is responsible. Date completed 9-26-2011	09/26/2011

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	shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Superior Systems &			

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	Supply "Smoke Detector Sensitivity Test Report for Highland Manor Healthcare" documentation dated 09/24/10 with the Maintenance Supervisor from 9:15 a.m. to 11:20 a.m. on 09/22/11, four smoke detectors located at "Smoke Detector No. Location" 2, 13, 16 and 17 were listed as "No" in response to the question "Detect Pass?" No other smoke detector sensitivity documentation was available for review. Based on interview the Maintenance Supervisor stated he did not know the four smoke detectors failed sensitivity testing and acknowledged there was no documentation available for review to indicate the four smoke detectors had been cleaned, repaired or replaced and retested.			
K0062 SS=F	3.1-19(b) Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review and interview, the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the	K0062	All residents, families, staff and visitors have the potential to be affected. 1. There is no solution for missing a previous quarter's inspection. Maintenance supervisor has been counseled on the importance of notifying Administrator of missing inspections. 2. Missing escutcheon plates have been replaced in the storage room by room 26 and the dining room	09/26/2011

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	authority having jurisdiction upon request. This deficient practice could affect 41 of 41 residents, all staff, and visitors in the facility. Findings include: Based on review of Superior Systems & Supply "Sprinkler System Inspection Form" documentation with the Maintenance Supervisor from 9:15 a.m. to 11:20 a.m., no second quarter 2011 (April, May, June) quarterly sprinkler system inspection documentation was available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged no second quarter 2011 sprinkler system inspection documentation was available for review. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect any resident, staff or visitor in the vicinity of the storage room by Room 26 and the Main Dining Room furnace room.		furnace room.3. Sprinkler head in the janitor's closet in the dining room has been replaced. Safety committee will monitor quarterly the sprinkler inspection reports and report to Administrator. Maintenance supervisor will during monthly maintenance rounds check all sprinkler heads for compliance and report to Administrator any deficiencies for repair. Safety committee will review reports for compliance quarterly. Maintenance supervisor is responsible. Completed 9-26-2011 and on-going	

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	Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, one sprinkler head in the storage room by Room 26 and in the Main Dining Room furnace room each had a missing escutcheon plate which left a two inch opening in the ceiling into the attic from each room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the storage room by Room 26 and the Main Dining Room furnace room sprinkler heads each had a missing escutcheon plates. 3.1-19(b) 3. Based on observation and interview, the facility failed to replace 1 of 1 sprinklers which had been painted. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the residents, staff			

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	and visitors in the vicinity of the janitor's closet in the Main Dining Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, the one automatic sprinkler head in the janitor's closet in the Main Dining Room had paint on the deflector. Based on interview at the time of observation, the Maintenance Supervisor stated he was not aware of paint on the deflector but acknowledged paint was on the sprinkler head deflector in the janitor's closet in the Main Dining Room. 3.1-19(b)			
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 7 portable fire extinguishers had pressure gauge readings in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly	K0064	All residents, families, staff and visitors have the potential to be affected. 1. Portable fire extinguisher in the basement at the bottom of the stairs has been charged to the appropriate level.2. There is no solution for missing a monthly inspection for July and August of the fire extinguisher in the mechanical room.3. The mechanical room fire extinguisher has been subjected to a “thorough check” as part of its annual maintenance. Safety committee	09/26/2011

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	check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect any staff or visitor in the vicinity of the basement fire extinguisher at the bottom of the stairs. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, the pressure gauge on the portable fire extinguisher in the basement at the bottom of the stairs showed the fire extinguisher was undercharged. The inspection tags on the portable fire extinguisher listed the most recent annual inspection was in June 2011 and the most recent monthly inspection was 09/12/11. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the portable fire extinguisher in the basement at the bottom of the stairs showed the pressure gauge indicated the fire extinguisher was undercharged. 3.1-19(b)		will monitor fire extinguishers during quarterly rounds of facility to ensure all fire extinguishers are in compliance. Maintenance supervisor is responsible. Date completed 9-26-2011	

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	2. Based on observation and interview, the facility failed to inspect 1 of 7 portable fire extinguishers for 2 of 12 months. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure a fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with, and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any resident, staff or visitor in the vicinity of the Mechanical Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, the inspection tag affixed to the portable fire extinguisher in the Mechanical Room lacked documentation of a monthly inspection for July and August 2011. Based on interview at the time of observation, the Maintenance Supervisor stated no other documentation			

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	of monthly inspections was available for review and acknowledged the portable fire extinguisher in the Mechanical Room did not have documented monthly inspections for July and August 2011. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 7 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect any resident, staff or visitor in the vicinity of the Mechanical Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, the inspection tag affixed to the portable fire extinguisher in the Mechanical Room indicated the most			

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	recent documentation of an annual maintenance occurred in July 2010. Based on interview at the time of observation, the Maintenance Supervisor stated no other documentation of annual maintenance was available for review and acknowledged the portable fire extinguisher in the Mechanical Room did not have documented maintenance at periods not more than one year apart. 3.1-19(b)			
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall	K0069	All residents, families, staff and visitors have the potential to be affected. Although financial records indicate the kitchen exhaust system was cleaned in the first quarter of 2011 per semiannual requirements, and the kitchen hood extinguishing system has been serviced in the last quarter of 2010, maintenance supervisor did not maintain appropriate documentation per LSC requirements. Safety committee will monitor semiannual reports for compliance and copies of documented servicing and cleaning will be delivered to Administrator for file compliance. Maintenance supervisor is responsible. Date completed 9-26-2011 and on-going	09/26/2011

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	be inspected semiannually. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen. Findings include: Based on review of Three Sixty Services "Service" records with the Maintenance Supervisor from 9:15 a.m. to 11:20 a.m. on 09/22/11, documentation indicated the kitchen exhaust system was last cleaned on 09/12/11 but no documentation of semiannual cleaning prior 09/12/11 was available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged no documentation of semiannual kitchen exhaust system cleaning prior to 09/12/11 was available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen.			

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	Findings include: Based on review of Condon, Inc. "System Service Order" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:20 a.m. on 09/22/11, the kitchen hood extinguishing system was last serviced on 06/16/11 and no documentation of semiannual kitchen hood extinguishing system service records prior to 06/16/11 was available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged no semiannual kitchen hood extinguishing system service documentation prior to 06/16/11 was available for review. 3.1-19(b)			
K0130 SS=F	OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure continuous operation of 30 of 30 battery operated smoke detectors in 30 of 30 resident rooms rooms to ensure the smoke detectors are continually maintained. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect all residents, staff, and visitors in the facility at the time of	K0130	All residents, families, staff and visitors have the potential to be affected. The monthly maintenance log has been updated to itemize the battery operated smoke detectors. Safety committee will monitor quarterly for compliance by reviewing the updated maintenance logs. Maintenance supervisor is responsible. Date completed 9-26-2011 and on-going	09/26/2011

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	this survey. Findings include: Based on record review with the Maintenance Supervisor from 9:15 a.m. to 11:20 p.m. on 09/22/11, the facility utilizes battery operated smoke detectors in all 30 resident rooms. Based on observation on 09/22/11 during the tour of the facility with the Maintenance Supervisor from 11:20 a.m. to 1:40 p.m., battery operated smoke detectors were observed in all resident rooms. Based on interview at the time of record review, the Maintenance Supervisor stated the facility performs monthly battery checks of smoke detectors but acknowledged there is no itemized log of battery operated smoke detector checks to ensure continuous operation. 3.1-19(b)			

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 2 areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity Room 25. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, resident Room 25 had one stationary liquid oxygen storage canister in a resident room. The stationary liquid oxygen canister was not in use by the resident who was not in the room. Based	K0143	All residents, families, staff and visitors have the potential to be affected. The liquid oxygen canister was removed from room 25 to the oxygen storage room. Oxygen transfer for this resident will follow the oxygen transfer policy and procedure as with any oxygen transfer. Safety committee will monitor compliance during quarterly rounds. Maintenance supervisor is responsible. Date completed 9-22-2011 and on-going	09/26/2011

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	on interview with the Director of Nursing at 12:45 p.m. on 09/22/11, the Director of Nursing stated the resident had a clinical need to utilize the liquid oxygen storage canister in the resident room but acknowledged the resident may leave the room on a daily basis without utilizing the liquid oxygen canister. The Maintenance Director and the Director of Nursing acknowledged the liquid oxygen canister observed in Room 25 was not in use by the resident in Room 25. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all residents, staff and visitors.	K0144	All residents, families, staff and visitors have the potential to be affected. 1. The generator contractor has been contacted by the owners of facility for placement of new emergency shut of switch. We are requesting a temporary waiver on this installation as owners do not believe the work can be completed before 90 days. 2. The generator logs have been updated to provide during monthly testing the percentage of load capacity and minimum exhaust temperature. 3. The generator logs have been updated to provide during monthly testing the transfer time to ensure sufficient capacity to pick up the load and meet the minimum frequency and	09/26/2011

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 09/22/11, no evidence of a remote shut off device was found for the 25 kilowatt natural gas fired emergency generator which had a manufacture date listed on the emergency generator label of January 2010. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there is no remote emergency shut off for the emergency generator. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 8 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS		voltage stability requirements of the emergency system within 10 seconds. Generator contractor in-serviced the maintenance supervisor on proper recording of the above issues in the log. Safety committee will monitor logs quarterly for compliance. Maintenance supervisor is responsible. Date completed to be determinedSee attached file	

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	(Emergency Power Supply) nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect 41 of 41 residents, all staff and visitors. Findings include: Based on review of the "Emergency Generator Record" monthly logs for January 2011 through August 2011 during record review with the Maintenance Supervisor from 9:15 a.m. to 11:20 a.m. on 09/22/11, the generator was run on a monthly basis for at least thirty minutes each month for the period of January 2011 to August 2011 but the logs utilized by the facility did not record what 30 percent of the generator name plate was, what percentage the load was when the generator load test was conducted or the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of review, the Maintenance Supervisor acknowledged the percentage of load capacity for the generator was not recorded nor the minimum exhaust gas temperatures as recommended by the			

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	manufacturer. 3.1-19(b) 3. Based on record review and interview, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems for 8 of 12 months. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice could affect 41 of 41 residents, all staff and visitors. Findings include: Based on review of the "Emergency Generator Record" monthly logs for January 2011 through August 2011 during record review with the Maintenance Supervisor from 9:15 a.m. to 11:20 a.m. on 09/22/11, the generator was run on a monthly basis for at least thirty minutes each month for the period of January 2011 to August 2011 but the logs utilized by the facility did not record the time to transfer power from the main source to the emergency generator. Based on interview			

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	at the time of record review, the Maintenance Supervisor acknowledged the transfer time to transfer power to the emergency generator was not recorded for each month. 3.1-19(b)			